Well, what can I say? The conference was a resounding success. Everyone I have spoken to has said how much they enjoyed the day and how informative the sessions were. Much credit should go to Rachel Matthews and Susannah Gray for all their hard work in the organisation of the event. Special thanks should also go to all the presenters and chairpersons without whom the day would not have been possible. The challenge that we now face is to ensure that next year’s conference is even better and the hard work has already begun.

The conference was also a pivotal point in the Association’s history with a change in name to the British Association for Nursing in Cardiovascular Care being accepted at the Annual General Meeting. This change heralds a new beginning for the organisation and is proof of our commitment to the prevention, care and rehabilitation of patients with wider cardiovascular disease.

Whilst I feel that this Council has achieved a great deal in the last year I believe a great deal more can, and will, be achieved by the end of our term of office in June 2007. The collaborations we have undertaken with the British Journal of Cardiac Nursing and the European Working Group in Cardiovascular Nursing have proved a massive success. Similar collaborations are currently being undertaken with additional partners to ensure we make the progress that our membership and their patients deserve. I will be happy to make these collaborations and projects public when the time is right to do so. However, I can promise you that as a council we are not resting on our laurels and are striving to take the organisation forward. I will continue to keep you updated over the coming months through our new electronic newsletter.

Best wishes
Ian
The abstracts - presented in the morning session - were of great interest as can be seen by the reports below and continued on page 3 opposite. Thanks to Belinda Linden for all synopses

1. Paramedics’ perceptions of their role in providing thrombolytic treatment in acute myocardial infarction: Qualitative study. H. Cox, J. Albarran, T. Quinn, K Shears

Helen Cox from the University of the West of England presented this qualitative study which explored the perceptions of paramedics whose role extended to delivering thrombolysis in the pre-hospital setting. This entailed 20 paramedics participating in focus groups. The discussions were taped from which various themes emerged which were analysed and validated. The main themes included having a duty of care, being drivers for change, their perceptions of the expansion of the roles and preparedness for practice, which reflected on their professional image. The overall impact for paramedics was mixed and this study reflected the need for the paramedics to be actively participating in this process of change as well as the need for multidisciplinary training, to gain clinical expertise, and to ultimately guide a national strategy. Resources would be needed to develop this role.

2. Client centred risk factor intervention in first degree relatives of patients with premature myocardial infarction. J. Oliver, M. Farrer

Jan Oliver from Sunderland Royal Hospital identified 241 first-degree relatives of patients who had suffered a myocardial infarction two months previously. These were screened for cardiovascular risk and given health promotion advice and followed up for 6 to 12 months. Over 60% of the relatives had one or more major coronary risk factors. This offered an important opportunity for health professionals to identify ways to encourage this high-risk group to successfully modify their risk of myocardial infarction.


Katrina Kotseva discussed the preliminary findings from the Euroaction study – a randomised-controlled trial within 2 hospitals in each of 7 European countries with a nurse led multidisciplinary team including 2 nurses, a dietician, and a physiotherapist. This was a 16-week trial involving assessment and a prevention and rehabilitation programme for 1060 patients and 637 spouses. Their preliminary findings suggest that many patients were successful in controlling their risk factors although the comparisons between the treatment and control groups are undergoing analysis in Ghent.


Kath Roche from the Princess of Wales Hospital addressed the impact of early health education and risk factor advice for patients admitted with unstable angina. 234 patients were randomised to either receive the intervention programme or usual care and after the study period the researchers analysed their knowledge, risk factors, general health, anxiety and depression scores. After the six week programme both of the groups benefited from improvements in these categories. This offers patients who have a high initial clinical risk the opportunity for early appropriate support and education although further study will be needed to clarify whether this early intensive intervention is of any additional benefit for specific patients groups.

Naila Rahman described how the symptoms of patients suffering from severe heart failure can include pain, shortness of breath, cough, depression and fatigue and compared the heart failure nurses’ and palliative care nurses’ perceptions of the needs of a heart failure patient. While the heart failure nurse described education, medication, drug management and symptom control to be main aspects of treatment the palliative nurse identified the social needs, spiritual needs, psychological needs, and symptom management. Afterwards the heart failure nurses and palliative care nurse specialists modified together the patients’ management plans and offered a more balanced holistic approach to care whilst also providing the vital advice on medication. This assessment tool showed how both teams could collaborate effectively to optimise the palliative and physical needs of patients with heart failure.


Ms Lennox described how patients with non-cardiac chest pain often remain anxious about their symptoms even after being reassured that they do not have a cardiac problem. This may be helped with an intervention involving feedback by encouraging them to explore their thoughts, emotions, behaviour and physiology. There was a need to understand their symptoms, their health beliefs with the support of a psychologist. 40 patients had usual care and 41 received the intervention. Although the intervention group understood their symptoms better, the emotional impact of the illness remained unchanged.

7. A District General’s experience of implementation of the NSF Chapter 8 arrhythmia and sudden cardiac death. The first two years of an innovative nurse-led rapid access atrial fibrillation clinic. D. Sevant

Debbie Sevant (Arrhythmia nurse - Southend) described the achievements of a cardioversion service, which encouraged rapid assessment of the patient, prompt risk assessment, a one-stop process of decision making to nurse, initiated cardioversion if the patient fulfils the criteria. They reported 100% success rate after 6 week follow up. This nurse-led rapid access atrial fibrillation management has for the last two years proved very successful particularly when compared with the long potential waiting period for referral to see a cardiologist.

8. Nurse-led prescription of low molecular weight heparins for acute coronary syndromes improves safety. Hudsmith, S. Haldar, S. Bull, N. Chahal, M. Brunton, C. McKenna, W. Orr,

Sacha Bull described how there could often be a failure in giving the correct dose of low molecular weight heparin for people with acute coronary syndrome. 64 patients with acute coronary syndrome were given dalteparin and the dosage was checked. This dose was calculated against the appropriate dose for the patients’ weight. She reported that 53% of patients had received an incorrect dose (34% were overtreated and 19% were undertreated). Once an education programme had been introduced and a weighing programme and chart developed to aid prescription 77% of patients received the therapeutic dose with 23% receiving too high a dose.
08:45-09:15 Mary Currie—National Standards do they Improve Patient Care?

Mary provided an excellent overview of the National Standards involved in cardiac care. The National Service Framework and its 12 standards has shown progress with improvements in primary and secondary prevention, speedier access to services, more resources for cardiac rehabilitation, more specialist nurses, an increase in rapid access chest pain clinics, speedier access to thrombolysis and reduced waiting times for cardiac surgery. National standards have had an impact in some areas, progress has been made but some areas have not benefited. Overall, mortality has fallen and it looks as though the government will meet its 40% target by 2010, with Scotland’s “Towards a Healthier Scotland” aiming to cut death rates even further. Discussion of why there has been a reduction of deaths from coronary heart disease focused on issues such as the natural history of disease, and advances in technology, and treatments. 40% of the reduction can be attributed to secondary prevention and treatments, and 50-60% to reduction in risk factors. Coronary heart disease management has shown pockets of excellence and pockets of inequity, which may be due to inadequate funding, restrictive resources, or failures with management. May Currie called for more resources, prioritising, leadership and vision, with imaginative approaches for wider sources of funding, identify incentives already in place, with more creative solutions to meet opportunities.

09:15-09:45 Dr Marcus Flather - The changing nature of ACS – what does it mean for future policy & practice?

Marcus Flather presented information on the leading research into acute coronary syndrome by illustrating a continuum of vascular risk. He stressed the need to focus more on vascular risk than on coronary disease alone. An estimated 400,000 coronary events occur in the UK each year, and of the survivors 20% die in a year, 10% suffer an infarction, and 15% undergo revascularisation. He stressed the huge task of guideline development with its extensive and careful research, and called for more input from nurses for this task as they appreciate the need for best practice through high standards. Marcus highlighted examples of new treatments such as the use of clopidogrel and aspirin after acute coronary syndrome, the potential advantage of fondaparinux with the OASIS study, comparing enoxaparin with heparin in reducing risk, the RITA-3 study comparing revascularisation with conservative treatment, and studies such as PRAIS (2000) and PROMIS (2005) identifying which treatments are being prescribed for patients with acute coronary syndrome. However this information needs to be disseminated more widely so that messages reach health professionals and ultimately benefit patients. Challenges include identifying markers of high risk; the importance of taking a history, developing an appropriate risk score minimising delays through time taken on governance and audit – electronic records could be the solution, looking at other health care systems, and having specialist vascular nurses to shape acute coronary syndrome care who can embrace coronary care, thrombolysis, and audit. Nurses have a key role in speaking out to ensure that the politicians listen and patients have the optimum care.
BANCC/BSH Joint Session. Chair Ms Jane Butler and Professor John Cleland.

The Afternoon session commenced with a Tribute in memoriam to Anne Townsend, by Tom Quinn. On behalf of BANCC, Tom spoke of the work of this pioneering Cardiac Nurse, and her outstanding contribution to Cardiac Care Nursing.

14:00 – 14:20 Heart Failure – Which Sector? Ms Jill Riley

Ms Riley discussed the roles of Secondary and Primary Care for patients with Heart Failure, and the service improvements required to move heart failure care into the community. Initiatives which have enabled this development range from policy initiatives, role development, and patient empowerment. The necessary components of care identified from discovery management programmes by Jill were; early detection of clinical deterioration, access to specific care, optimisation of medicines, education, exercise, counselling and psychological support and self care strategies.

Models of care discussed in more detail were: (i) Intensive home visits according to need - pioneering work by Linda Blue in Glasgow which resulted in a reduction in heart failure admissions to hospital; (ii) clinic-based follow up, with an intensive clinic based programme over 12 months; (iii) telephone-based follow up of high risk patients following discharge from hospital; (iv) home telemonitoring. The Study cited involved a 240 day follow up via telemonitoring. An increase in readmission rates showed in this study was thought to be a positive finding, as deteriorating patients were detected early, and consequently admissions were appropriate, and also dramatically shorter.

Ms Riley summarised that it is appropriate to move heart failure care into the community. This however requires good liaison, easy access to secondary and tertiary care, a sound evidence base, and an empowered patient.


This interesting and informative session gave an overview of a model of care delivery for heart failure patients in the community setting, the lessons learned, and changes made along the way, in a model in which District Nurses were seconded to form part of the Specialist Nurse Team. This team based their model on the fact that the best studies in this area showed that structured and planned care was often delivered via a multidisciplinary team, and often with a nurse co-ordinator. This team’s interest was in bridging the interface between hospital and community care.

Lessons learned were that it takes time to develop a Specialist Nurse Team, and also to develop relationships and partnerships with others. It is difficult to discharge even ‘low risk’ patients, and that all contacts should be recorded. Successes were in developing a comprehensive database over the 2.5 year pilot project. All cause admission to hospital was reduced by 89% in this group, and admissions for worsening heart failure were reduced by 94%. Length of stay was reduced by 46%. Key ideals were felt by the team to be; that patients value ongoing care, working across the hospital/community interface is valuable and allows trusting relationships with colleagues to develop, and that partnerships with patients enable self management.
14:40 – 15:00 Nurse Prescribing. Mr John Carson

Mr Carson gave an overview of the experiences of the Lanarkshire Heart Failure Service in developing Nurse Prescribing within that team. Benefits of Nurse prescribing to heart failure patients were described as promoting individualised care and evidence based medicine, delivering effective therapy promptly, and reducing clinic/surgery visits. Similarly, benefits to the prescriber are greater autonomy, nurturing of relationship with patient, improving time management, and encouraging a sense of accountability and self development. Training and Education aspects within the Scottish Health Care System, and the role of the Trust were described. Of the three possible routes - of utilising Patient Group Directions, Supplementary Prescribing, or Independent Prescribing, Mr Carson recommended that supplementary prescribing was the most appropriate tool for delivering care to heart failure patients.

In summary, the development of this team of Heart Failure Nurses has in fact advanced more quickly than current prescribing legislation. Currently, Lanarkshire has agreed medical therapy guidelines, PGD’s are used for the delivery of Beta Blockade and diuretics, and a GP or Cardiologist signature is required for all other medication changes. Challenges for the future for this team, who are soon to be Registered Prescribers, include improving competency, auditing their practice, integration of new services, and working within a national strategic framework.

15:00 – 15:20 Pharmacy Heart Failure Service. Mr Paul Forsyth

Mr Forsyth described a novel Community Pharmacy based service in Glasgow. Patients are referred into this service by either a Heart Failure Specialist Nurse, or General Practitioner. Currently 195 out of 220 Glasgow Pharmacies are signed up to this project, with 321 Pharmacists currently trained. 795 referrals have been received so far, with 1.5% of patients subsequently opting out. Little evidence in this field is currently available, although current studies have been commissioned.

The aim of the service is to improve the patient’s knowledge of their condition, medication, and symptom recognition. The service was developed as non-compliance in patients aged > 60 years varies from 26% – 59%, and 15% of readmissions with heart failure are caused by non-compliance. Knowledge and beliefs play a key role in compliance with prescribed medications, and greater understanding leads to greater overall concordance. ‘Concordance’ was described as ‘a process of prescription and medication taking based on a partnership’ and this term is used in preference by this team to ‘non-compliance’.

At each contact the Pharmacist gauges concordance and baseline symptoms, identifies patient’s knowledge, and reinforces symptom recognition. The Pharmacist follows up each patient every 28 days. Patients identified with worsening heart failure at these visits are referred to either HF Nurse or GP. This is a novel service, and represents new working practice for Pharmacists.

Summing up by Chair

In summarising this session, Prof John Cleland stated that Nurses and Pharmacists were taking a much more active role in prescribing and monitoring medicines for heart failure patients, and also in ordering tests, resulting in the delivery of a more comprehensive multidisciplinary care package.

He added that for progress to continue, the Government needed to get their incentives right in terms of charges.
An Opportunity for Learning and Networking for Cardiovascular Nurses in Europe

The Working Group on Cardiovascular Nursing of the European Society of Cardiology (WGCVN) held its 6th Annual Spring Meeting in Bergen, Norway 5-6 May. The theme of the meeting was New Frontiers in Cardiac Care, and it was co-sponsored by the Norwegian National Society of Cardiovascular Nurses. The programme was two full days of nurses (and a few physicians) discussing the latest information about clinical practice, sharing ideas and experiences, presenting clinical projects and research, and networking with colleagues from across Europe and North America. Over 400 delegates attended the sessions, including many nurses from the U.K. Jenny Tagney and Christi Deaton of BANCC were invited speakers. Delegates also attended a reception in the 13th century Hakonshallen (a former royal residence), and enjoyed a Norwegian band and singers. Comments from the delegates after the meeting were very positive about the quality of the presentations and the ideas and energy generated.

** FORTHCOMING EVENT **

Next year, the 7th Annual Spring Meeting will be jointly sponsored by BANCC and WGCVN, and will be held 23 – 24 March 2007 in Manchester. This is a tremendous opportunity to not only share our knowledge and learn from each other, but to showcase the wonderful work that is being done in the U.K. Please put those dates in your diary, and plan to be part of this exciting event!

Christi Deaton Ph.D., RN, FAHA
Professor of Nursing
School of Nursing, Midwifery & Social Work
The University of Manchester
Cardiac Nursing Awards and forthcoming events

Cardiac Nursing Awards 2007
The BANCC and the British Journal of Cardiac Nursing, launched in January 2006, have joined forces to stage the Cardiac Nursing Awards 2007. The aim is to ensure that this important and developing branch of nursing rewards excellence. A panel of well-respected judges, including BANCC President Ian Jones, will adjudicate 11 awards. The finalists of each category will be invited to attend a prestigious awards ceremony, which will be held at the Cafe Royal, Piccadilly, London on the evening of Friday April 20, 2007. Entries are open to any nurses, whether working in clinical practice, education or research, who are working in or have an involvement with cardiac nursing. For more information on the award categories and how to enter please contact BANCC at bancc@bcs.com.

NICE Familial Hypercholesterolaemia guideline: nominations for the Guideline Development Group

Title: Clinical guideline for the identification and management of patients with familial hypercholesterolaemia. Remit: “To prepare a clinical guideline for the NHS in England and Wales for the identification and management of patients suffering from Familial Hypercholesterolaemia to include advice regarding the optimal approach to case identification, cascade screening, medical management and the use of apheresis.

BANCC have been asked to nominate an active cardiology nurse specialist with experience in dealing with adults with familial hypercholesterolaemia. Professional nominees do not have to be ‘experts’; the Guideline Development group needs healthcare professionals who treat patients on a day to day basis in typical NHS circumstances. There are likely to be 10-12 meetings over an 18 month period.

If you would like to take part on behalf of BANCC or would like more information please email your interest to bancc@bcs.com by Wednesday 12 July, 2006.

Miscellany

♦ Members will soon be receiving a form which, when filled in and returned to BANCC, will allow reimbursement of BANCC membership annual subscription. The Annual General Meeting (AGM) minutes will also be sent to members. If you haven’t received these soon, please contact BANCC at banc@bcs.com or call 020 7692 5413.

♦ The new MINAP public report is now available at www.library.nhs.uk/cardiovascular
Provided below is a list of BANCC members who have an interest in research and who are willing to support junior researchers in their activities. This is an updated version of the form which was printed in the Spring newsletter.

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BANCC NEWSLETTER

Got an idea? Doing something innovative? New ideas or initiatives? Areas of good practice?

SHARE YOUR VIEWS WITH YOUR COLLEAGUES

This is your newsletter and needs your contributions. We welcome features from our readers

Please send your news to Susannah Gray at the
British Cardiovascular Society, 9 Fitzroy Square, London, W1T 5HW

Useful Websites or email addresses

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Cardiac Risk in the Young - CRY
Http://www.rms.nelh.nhs.uk/cardiovascular
National Electronic Library for Health/Cardiovascular specialist library

REQUEST FOR MEMBERSHIP
APPLICATION FORMS

If you would like to join the British Association for Nursing in Cardiac Care (BANCC), please print off and complete the following and we will forward you an application form(s)

NAME ____________________________________________

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Number of forms required _________

Please cut out this form and send it to

Susannah Gray
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